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PRINTED: 09/04/2007 FORM APPROVED OMB NO. 0938-0391

	D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUIL	DING	COMPLETED		
		09G145	B. WING	G	R 08/28/2007		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
{W 100}	This follow up sur and 28, 2007. The clients selected from July 13, 2007 and in the previous As a result of issurand record review was determined to improvements we continued to not in Condition Levels of Body, Facility Staff. The findings of this from staff interview record reviews to clinical, and incide reports involving a 7/23/07 and an all also reviewed. 440.150(c) ICF SE INSTITUTIONS. "Intermediate care services in an inst (hereafter referred facilities for person with relating (1) The primary purpovide health or improvide health or improvide health or improvide to the conditions (2) The institution E of Part 442 of the client of the conditions (3) The mentally reservices in an institution in the conditions (3) The mentally reservices in an institution in the conditions (3) The mentally reservices in an institution in the conditions (3) The mentally reservices in an institution in the conditions (3) The mentally reservices in an institution in the conditions (3) The mentally reservices in an institution in the conditions (4) The mentally reservices in an institution in the conditions (4) The mentally reservices in an institution in the conditions (4) The mentally reservices in an institution in the conditions (4) The mentally reservices in an institution in the conditions (5) The mentally reservices in an institution in the conditions (5) The mentally reservices in the conditions (6) The mentally reservices in the conditions (7) The mentally reservices in the conditions (7) The mentally reservices in the conditions (7) The mentally reservices in the conditions (8) The conditions (8	vey was conducted August 27 client sampling included three om the initial survey conducted and two other clients who was sample. es derived from staff interviews, during the follow up survey, it not although some re identified, the facility has neet compliance at the of Participation in Governing fing, and Active Treatment. Is follow up survey were derived ws at the group home and include medical, administrative, ants reports. Two investigative an allegation of abuse on egation of theft on 7/15/07 was ERVICES OTHER THAN IN Is facility services" may include itution for the mentally retarded to as intermediate care as with mental retardation) or ed conditions if: urpose of the institution is to rehabilitative services for individuals or persons with meets the standards in Subpart as Chapter; and etarded recipient for whom sted is receiving active	{W 10				
ABORATOR	<i>_</i>	IDER/SOPPLIED REPRESENTATIVE'S SIGN	NATURE	Tyle	1-	(X6) DATE	

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days formowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		09G145	B. WIN		1	⋜ 8/2007
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	TO SERVICE TO THE A	HOULD BE	(X5) COMPLETION DATE
{W 100}.	This STANDARD Based on interview facility's governing to implement control monitoring of the proportunities acconstruction (POC) The finding include Interview with the Professional (QMF was acknowledge scheduled for the month, record reviactive treatment h	is not met as evidenced by and record review, the body and management failed ols to ensure a more rigorous ovisions of continuous learning rding to the facility's Plan of dated 8/20/07. ES: Qualified Mental Retardation RP) on 8/27/07 at 5:40 PM, it d that the case reviews first and third Tuesday of each ews, and monthly analysis of ad not been implemented.	{W 10	management of MarJul has implemented more of to ensure a more rigorous monitoring of the provision continuous learning opposes follows: 1) Case Review—I Tuesday of each month 2) QA Consultant a) record review b) monthly anallactive treatment See attachment #1 The governing body we monitor, and revise, as policies and operating of the provision of the provisio	Homes controls is ion of ortunities st & 3 RD ysis of ill provide, necessary, directions	9-2607
{vV 102}	the case review w (LPN) and House see documentatio acknowledged tha sheet present in the Also see Federal W249 and W196 483.410 GOVERN MANAGEMENT The facility must e body and manage	Deficiency Report Citations	{w -	which will ensure the n staffing, training resour equipment and environ provide individuals wit treatment and to provide health and safety. This accomplished by: 1) Revising the progradirector job description attachment # 2 2) Following the recommendations and vector cooperatively with the quality assurance constattachment # 2	rces, ment to h active le for their will be am . See working internal	4260

TATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN B. WING _		(X3) DATE SUI COMPLET R 08/28	ED
	ROVIDER OR SUPPLIER	030140		REET ADDRESS, CITY, STATE, ZIP CO 4910 ARKANSAS AVENUE, NW	DE	
MARJUL	HOMES			WASHINGTON, DC 20012	PECTION	(X5)
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{W 102}	general operating ensure the provising facility staffing [So The systemic effer follow-up visited coof the governing by govern the facility needs and service and W195] 483.410(a)(1) GC The governing by	ning body failed to maintain direction over the facility to on of active treatment and	{W 102			
	Based on observer record reviews the ensure that the fabudget, and oper. The findings included in the findings in the finding in the fi	the Qualified Mental Retardation MRP) on 8/27/07 at approximately acknowledged that the facility ed Clients #1, #2, #3, and #4's guardian, and/or family members ts forms or inform them about effects of psychotropic which they were currently liew of the Individual Support Plant 8/27/07 at approximately 5:50 consents forms had been ents 1 through 4. There was no		1. The governing bo Program Director in with the Quality Ass Consultant will ensuindividuals parents/guardians/ad informed of all meditheir side effects, and have given consents treatments. See attack	conjunction urance re that all the vocates are cations and d that they for all	9/26/5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	OWNEDHON		A. BUII B. WIN			1	R
		09G145	10			08/2	8/2007
	ROVIDER OR SUPPLIER . HOMES			49	EET ADDRESS, CITY, STATE, ZIP CODE 10 ARKANSAS AVENUE, NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 104}	parents/guardians/ all medications and have given conser- in the Plan of Corre 2. The governing clients #1, #2, and a consistent and p	advocates had been informed their side effects, and they at for all treatments as indicated ection dated 8/20/07. body failed to ensure that the #3 received active treatment in ersistent manner as described	{W 1	04}	2. See W196		
{W 124}	policies were imple protection of client 483.420(a)(2) PRO RIGHTS The facility must end Therefore the facility parent (if the client of the client's mediand behavioral st	body failed to ensure that the emented to ensure the strights. [See W264] DTECTION OF CLIENTS Insure the rights of all clients. lity must inform each client, it is a minor), or legal guardian, lical condition, developmental atus, attendant risks of the right to refuse treatment.	{W 1	24}	3. See W264		
	This STANDARD Based on staff interpretation facility failed to endeveloped to assistanctioned advocatheir rights due to	is not met as evidenced by: erview and record review, the sure that a system had been st clients through legally acy to ensure the protection of their behavioral status, risk of sire to refuse treatment for four le sample.					
	Interview with Retardation Profe	de. the Qualified Mental essional (QMRP) on 8/27/07 at i8 PM, it was acknowledged that					

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E-CONSTRUCTION	COMPLETED	
ND PLAN O	F CORRECTION	ibertii loation toimberii	1	LDING	· · · · · · · · · · · · · · · · · · ·	L .	R
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	OF PROVIDER OR SUPPLIER JUL HOMES ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			491	ET ADDRESS, CITY, STATE, ZIP CODE 10 ARKANSAS AVENUE, NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{W 124}	the facility have not and #4's advocated members to obtain them about the usus psychotropic medicurrently prescribed Support Plan (ISF approximately 5:5 forms had been of There was no docuparents/guardians all medications at the page of the process of the page of the pa	ot contacted Clients #1, #2, #3, e, legal guardian, and/or family in consents forms or inform se and side effects of ications in which they were ed. Review of the Individual P) records on 8/27/07 at 50 PM revealed no consents obtained for Clients 1 through 4. Cumented evidence that the s/advocates had been informed and their side effects, and they ent for all treatments according to	{W 1	24}	1. See W104 #1		
	Professional (QM 5:58 PM, it was a have not contacte advocate, legal g to obtain consent the use and side medications in w prescribed. Revi (ISP) records on PM revealed no obtained for Clied documented evic parents/guardiar all medications a have given consthe facility's POC there was no evi Registered Nurs calls to the advo	the Qualified Mental Retardation IRP) on 8/27/07 at approximately scknowledged that the facility ed Clients #1, #2, #3, and #4's uardian, and/or family members to forms or inform them about effects of psychotropic hich they are currently lew of the Individual Support Plan 8/27/07 at approximately 5:50 consents forms had been into 1 through 4. There was no dence that the is/advocates had been informed and their side effects, and they ent for all treatments according to dated 8/20/07. Additionally, dence that the facility's e (RN) made follow up phones cate, legal guardian, and/or to ensure all their questions and			2. The governing body, we Program Director in conjugation with the Quality Assurance Consultant will ensure that individuals parents/guardians/advocatinformed of all medication their side effects, and that have given consents for a treatments. Additionally will make a follow up cal parents/guardians/advocatensure that all their quest concerns have been thorough the program of th	tes are they the RN to the tes to they tes to the tes to	9-2607

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	G	_	3
		09G145	B. WII	1G		1	8/2007
NAME OF P	ROVIDER OR SUPPLIER			49	REET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW		
MARJUL					VASHINGTON, DC 20012 PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	QULD BE	COMPLETION DATE
{W 148}	The facility must no parents or guardia changes in the clie	otify promptly the client's n of any significant incidents, or nt's condition including, but not illness, accident, death, abuse,	{W 1	48}			
	Based on interview facility's QMRP fai individuals parents notified of medical treatment and this the Program Direct Consultant accord 8/20/07 for four of	is not met as evidenced by: v and record review, the led to ensure that the s/guardians/advocates were tions, consents, injuries, or procedure will be monitored by ttor and the Quality Assurance ing to the facility's POC dated five clients included in the #1, #2, #3, and #4)					
	Professional (QMI 6:18 PM, it was at have not contacte parent/guardian/a medications, consthere was no evident through 4 records parents/guardians of medications, constructions, construc	the Qualified Mental Retardation RP) on 8/27/07 at approximately eknowledged that the facility d Client #1, #2, #3, and #4 dvocates to notify them about sents, injuries or treatments. In the indicate that the sadvocates had been informed onsents, injuries, or treatments. The indicate that the sadvocates had been informed onsents, injuries, or treatments. The indicate that the facility's Registered that the facility's Registered in made follow up phones calls regal guardian, and/or family are all their questions and the interview and een thoroughly answered as		· ·	1. The QMRP will ensur the individual's parents/guardians/advoca notified of medications, or injuries or treatments and procedure will be monitor the Program Director and Quality Assurance Constant Attachment* 2. Following all signing consent forms by the indeparents/guardians/advoc facility RN will make a call to ensure that all the questions and concerns thoroughly answered.	of ividual's ates the follow-up	9.26.07

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '		E CONSTRUCTION	COMPLET	
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER		LDING		F	₹
		09G145	B. WIN	NG		08/28	3/2007
NAME OF PI	ROVIDER OR SUPPLIER			491	ET ADDRESS, CITY, STATE, ZIP CODE 0 ARKANSAS AVENUE, NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix .	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	8/20/07. 483.420(d)(4) STACLIENTS The results of all it to the administrate or to other officials within five working This STANDARD Based on interview failed to ensure the to the administrate or other officials in five working darclients included in The finding included Review of an inveon 8/27/07 at application and pushed investigative report, Client #1 a informed staff the home pulled his ledown, and pushed investigative reports igned off on by the Department of days later). Inter Retardation Professorroximately 5:	an of Corrections dated AFF TREATMENT OF Investigations must be reported or or designated representative in accordance with State law days of the incident. Is not met as evidenced by: It wand record review, the facility at investigations were reported or or designated representative in accordance with state law with ys of the incident, for one of five the sample. (Clients #1)		148}	The QMRP will ensure facilities Incident Mana Coordinator completes submits all investigation five working days and sthem to the Department Health.	gement and ns within submits	9.260
{W 158	days. 3 483.430 FACILIT	Y STAFFING	{V	/ 158}			

STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED R	
		09G145	B. WIN			08/28/2	2007
NAME OF PE	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE I	(X5) COMPLETION DATE
{W 158}	Continued From particle facility must e staffing requireme	nsure that specific facility	{W 1	158}	·		
	Based on staff into facility failed to en treatment progran and monitored by Retardation Profe and failed to ensu	is not met as evidenced by: erviews and record review, the sure that each client's active n was integrated, coordinated the Qualified Mental ssional (QMRP) [See W159]; re staff were adequately trained mplementing iactive treatment avior interventions [See W189					
· · · · · · · · · · · · · · · · · · ·	follow-up visited of failure to provide active treatment s						
	*********	***********************					
	record review, the each client's activintegrated, coord Qualified Mental (QMRP) [See Wwere adequately implementing inc.]	ations, staff interviews, and a facility failed to ensure that we treatment program was inated and monitored by the Retardation Professional 159]; and failed to ensure staff trained on appropriately etive treatment program and ations [See W189 and W191].					1
{W 159	the facility's failuensure active tre 3 483,430(a) QUA	ese systemic practices results in re to provide adequate staffing to atment supports. LIFIED MENTAL PROFESSIONAL	'	/ 15	9}		

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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		09G145			EET ADDRESS, CITY, STATE, ZIP CODE	08/28	8/2007
MARJUL	ROVIDER OR SUPPLIER HOMES			49	910 ARKANSAS AVENUE, NW		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE APPR	OULD BE	(X5) COMPLETION DATE
{W 159}	integrated, coordin qualified mental re This STANDARD Based on interview Mental Retardation QMRP failed to en treatment program established, integramonitored; failed to the stable of	e treatment program must be ated and monitored by a tardation professional. is not met as evidenced by: ys, staff, and the Qualified of Professional (QMRP), the sure that client's active to include interventions were ated, coordinated and of ensure the protection of the professional to the profession of the professi	{W 1	59}			
•		de: ed to ensure that clients us active treatment services.			1. See W196 & W249		
{W 189}	[Refer to W196, W 2. The QMRP fail objective criterions had been consider success for the cli	,	{W	189}	2. See W257		
	initial and continui	rovide each employee with ng training that enables the orm his or her duties effectively, npetently.					
-	Based on observative review, the facility employee was protraining that enable	is not met as evidenced by: utions, interview, and record failed to ensure that each ovided with initial and continuing ed the employee to perform his ctively, efficiently, and					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION G	COMPLI	ETED
		09G145	B, WI	۷G		l l	R 28/2007
NAME OF P	ROVIDER OR SUPPLIER		_ .	49	EET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 189}	Continued From p competently. The findings included the findings	de: the Qualified Mental Retardation RP) on 8/27/07 at approximately exnowledged all staffs had not applementing the Client #1's Plans (BSP). Review of the entation records on 8/28/07 at 40 PM revealed six out of aff had been in service on Client was no documented evidence and trained all staffs on correctly ent #1's BSP as indicated in the approximate of the entation records on 8/20/07. The noted that one of four new second shift (4 PM to 12 PM) on eved training on the Client #1's envestigative report dated approximately 3:55 PM mendation that included all port staff professionals should how to correctly handle all Interview with the Qualified on Professional (QMRP) on simately 7:00 PM revealed that it a new system in place to track of the CMRP indicated that takes a purchase from the store,	{W 1	89}		sure uals o retrain orther ogist er year	9.26.07
	made from the pu	est a copy of the the receipt urchase from the store tor the client's change to ensure he correct amount back made					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (189) Continued From page 10 from the purchase c. Staff will turn the receipt into the Home Supervisor d. The home supervisor will forward the receipt the Administrator e. The administrator will file all receipts into the clients records. At approximately 7:07 PM on 8/20/07, Client #		_1	49	EET ADDRESS, CITY, STATE, ZIP CODE 10 ARKANSAS AVENUE, NW ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG	ix	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 189}.	from the purchase c. Staff will turn the Supervisor d. The home super the Administrator e. The administration of the Administration of the Administration of the Administration of the According to the According	e receipt into the Home ervisor will forward the receipt to tor will file all receipts into the 2:07 PM on 8/20/07, Client #3 In the local corner store, irect care staff, Client #3 If coffee, chips and a soda with ir bills. Staff indicated that he ent to see how much his items change he had gotten back, indicated that he did not ask for a is no evidence that staff y's system on tracking the effective. Conducted on 8/27/07 from 3:30 evice was not used. Interview Mental Retardation RP) on the same day at 5 PM acknowledged that staff ing Client #2's communication ince with the Individual Support time of the survey. The QMRP	{W 1	89}	The facility will implement following system. 1. The staff will be inserviced on handli individual funds quarterly. 2. The staff will requeduplicate receipts for ALL individual's purchases and rendeservices (haircuts, e.g., and the House Supervisor. 4. The House Supervisor will copy the receipt put the copy in the individual's financi book and the origin be sent to the Market Homes Business Of for filing in the dup individual's financi book.	ing ered etc.). e e sor ot and ial ial will ul ffice olicate	9-2607
	indicated that she communication d indicated that she not received train communication d 8/27/07 at approxobjective that readevice to name the time with total question of the communication of the co	was unaware of how to use the evice. The QMRP further and the direct care staffs had ing on the used of the evice. Record verification on the cimately 7:22 PM revealed and "will use his communications wo different items at any given idance. Further review of the cientation record revealed no			3. The QMRP has sched in service in which a representative from Assi technologies will be train how to correctly operate individuals communicated device See Albertment.	istive n staff on the ion	92607

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	COMPLETED		
		09G145	B. WIN	۷G			B/2007
NAME OF P	ROVIDER OR SUPPLIER		1	49	EET ADDRESS, CITY, STATE, ZIP CODE 110 ARKANSAS AVENUE, NW (ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{W 189}	evidence that all far had been trained by pathologists. There evidence that the of implemented as re-	cility staffs including the QMRP y the speech and language e was no documented bjective was being	 {W 1		7		
{W 191}	View in-service trai process. It is predi levels of staff can s enable the individu consistent, wide-sp	ining as a dynamic growth icated on the view that all share competencies which al to benefit from the pread application of the red by the individual's particular	(
<u>)</u>	in-service training p demonstrated com relevant to the indiv as in terms of the " caregivers and the relationships with the staff's knowledge the good transdiscipling	s, the adequacy of the program is measured in the petencies of all levels of staff vidual's unique needs as well affective" characteristics of the personal quality of their he individuals. Observe the by observing the outcomes of ary staff development (i.e., in stive treatment) in such inpetencies as:			·		
-	Respect, dignit individuals (e.g., h refer to W150);	ty, and positive regard for ow staff refers to individuals,					
	Use of develop	principles in training en staff and individuals; emental programming iniques, e.g., functional training nalysis, and effective data					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		09G145	B. WIN	G		R 	
NAME OF P	PROVIDER OR SUPPLIER			4910 A	ADDRESS, CITY, STATE, ZIP CODE RKANSAS AVENUE, NW HINGTON, DC 20012		10/2007
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
(W 191)	detection and prevere individual safety, en Use of adaptive communication devindividuals achieve self-help skills; and Use of positive programming. §483.430(e)(2) Pro Does the staff training needs of the individual program? Does observation of individuals reveal the	e procedures regarding abuse ention, restraints, medications, nergencies, etc.; mobility and augmentative ices and systems to help independence in basic behavior intervention bes ng program reflect the basic uals served within the f staff interactions with at staff know how to alter their atch needs and learning style	{W 19	91}			
		work with clients, training and competencies directed vioral needs.					
	Based on interview a	not met as evidenced by: and record review, the facility rained direct care staff on strategies.					
	The findings include	:					
	including new staff h	to ensure that all staff ad been trained on Client ort Plan (BSP). [See W189]		1.	See W189		

PRINTED: 09/04/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING R B. WING 09G145 08/28/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW MARJUL HOMES WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {W 191} Continued From page 13 {W 191} 2. Review of an investigation Report dated 8/1/07 on 8/27/07 at approximately 3:30 PM revealed a 2. See W189 recommendation that all direct staff personnel should be in serviced on Client #1's BSP with a focus on the proactive strategies as outlined by the psychologists. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 5:22 PM, it was acknowledged that only six of fifteen staff had been trained on Client #1's BSP since the incident occurred on 7/23/07. Further interview with the QMRP revealed that only one of four staff working the second shift on 8/20/07 had received training on Client #1's BSP. Review of the inservice/orientation record on 8/28/07 at approximately 12:50 PM revealed an in service training dated 8/15/07. The training indicated that six of fourteen staffs had been trained on Client #1's BSP. Additional record review and interview with the QMRP revealed there was no other class. scheduled for the other staff to received training on Client #1's BSP at the time of the survey. {W 195} 483.440 ACTIVE TREATMENT SERVICES {W 195} The facility must ensure that specific active treatment services requirements are met.

W264].

This CONDITION is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide clients' with continuous active treatment [Refer to W196 and 249]; failed to revise programs/objectives as needed [Refer to W257]; and failed to ensure that the policies of the facility were implemented to ensure the protection of clients rights [Refer to

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
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(W 195)	Continued From pa	ge 14	{W 19	5}		
nu 100)	practices results in deliver statutorily m clients.	ect of these systemic the failure of the facility to andated active treatment to its		See W196, W249, W2:	57, W264	
(W 196)	treatment program, consistent impleme specialized and gen services and related subpart, that is direct (i) The acquisition the client to function determination and (ii) The prevention	ceive a continuous active which includes aggressive, entation of a program of eric training, treatment, health a services described in this cted toward: of the behaviors necessary for	{W 19	6}		
	Based on interview facility's manageme staff meetings to en of all Individual Prog Additionally, the QM record reviews of all corresponding week analysis of the indivithe facility's POC daclients included in the #3, and #4) The findings include 1. Interview with the Professional (QMRF	PP failed to conduct weekly IPP's and write a ly note to ensure proper duals progress according to ted 8/20/07 for five of five e sample. (Clients #1, #2,				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
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{W 196}	reviews and notes I proper analysis of C progress. Further i revealed that the hodaily review to ensure evidence or system were being conduct. There was no documonthly scheduled ensure continuous additionally, there we that the QMRP concorresponding weel analysis of the client.	nad not been done to ensure Clients #1, #2, #3, and #4 Interview with the QMRP ome supervisor will perform are data is being documented in place of how the reviews ted by the home supervisor. In the mented evidence that a had been implemented to staff training of all IPP's. It was no documented evidence ducted weekly records, wrote kly notes to ensure proper its progress, and that they erformed daily reviews to	{W 1	1. The QMRP will ovisual record review weekly, and incorporation findings and outcome routine QMRP note	v and initial orate the nes in the		
	Retardation Profess 6:32 PM acknowled conducted any monteach them basic significant teach them basic significant teach between communication skill service/orientation in one evidence that an received training on no documented evid supervisor conducte to teach basic sign POC dated 8/20/07. b. Interview with the Professional (QMRF acknowledged acknowledged acknowledged acknowledged acknowledged any visits to the conducted to the professional (QMRF acknowledged acknowled	the Qualified Mental sional (QMRP) on 8/27/07 at ged that she had not thly in service for all staff to gn language and to encourage individuals and enhance their s. Review of the staff in ecords on 8/28/07 revealed y of the facility staff had basic language. There was dence that the home ad monthly in service for staff language as indicated in to e. Qualified Mental Retardation P) on 8/27/07 at 6:37 PM owledged that she had not not correction dated 8/20/07.		2a. The Home super conduct a monthly is all staff to teach the language and to encounteraction between and enhance their conskills. See attachment 2b. The QMRP will regular day program at least once monthly encourage communication their regular and their regular attachment # 8	n service for m basic sign ourage individuals ommunication ent # \(\cdot \) perform observations y to cation als' day	9.H.O7	

PRINTED: 09/04/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G145 08/28/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW MARJUL HOMES WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {W 196} Continued From page 16 {W 196} 3. Interview with the Qualified Mental Retardation The OMRP will conduct a visual Professional (QMRP) on 8/27/07 at approximately record review and initial weekly. 6:30 PM acknowledged that the weekly record and incorporate the findings and reviews and notes had not been done to ensure outcomes in the routine OMRP proper analysis of Clients #1, #2, #3, and #4 note. / progress. Further interview with the QMRP revealed that the home supervisor will perform daily review to ensure data is being documented. Record verification revealed no documented evidence or system in place of how the reviews were being conducted by the home supervisor. There was no documented evidence that a monthly scheduled had been implemented to ensure continuous staff training of all IPP's. Additionally, there was no documented evidence that the QMRP conducted weekly records, wrote corresponding weekly notes to ensure proper analysis of the clients progress, and that they home supervisor performed daily reviews to ensure data was being documented. Based on observation, staff interviews and record review, the facility failed to ensure that clients #1 and #2 were provided the opportunities for continuous active treatment in accordance with their individual program plans (IPPs). The findings include: 1. Client #1's IPP was reviewed on July 13, 2007 at approximately 7:25 PM. The documentation of program data was also reviewed. It was revealed

through this review that client #1 had a program to use public transportation once bi-weekly independently upon request. The documentation

reflected that client #1 used the public

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on Jarotember June, a reflect e object failed for use reflect for used for use	nuary 6, 2007, March 31, or 30, 2006. There was no and July 2007. For May ted that client #1 had stive once for the month. Ito provide consistent recommended methods of erved not using verbal as, or any communicative arvey on July 12, 13, and 16 eech assessment dated two 6, 2005) was conducted by ist at the client's day sional identified that client #2 angths: "following situational social commands, making arough the production of a anguage signs, and ag a few pictures." The cluded: increase skills in sign and following directions and that speech services in be similar to the services for and the provided in a daily and instructors were lessigns (eat, drink, toilet, unicate. According to the rand the provided #2 achieved signing lry hands at the criterion of ting. No signing was	{W 1	96}	1. The facility has implement a schedule to ensure that each individual's travel training is completed on a regular basis. See attachment #4	h	9,2607
	PLIER RY STATCLENCY I Y OR LSO om pag on Jarentees a reflect e object failed from the survey of t	OPG145 PLIER RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) Om page 17 on January 6, 2007, March 31, Detember 30, 2006. There was no June, and July 2007. For May a reflected that client #1 had be objective once for the month. failed to provide consistent to use recommended methods of	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G145 PLIER RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) PREFITAGE TAG OTHER RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION) TO January 6, 2007, March 31, otember 30, 2006. There was no June, and July 2007. For May a reflected that client #1 had e objective once for the month. failed to provide consistent to use recommended methods of ns. Tas observed not using verbal ns, signs, or any communicative of the survey on July 12, 13, and 16 (2's speech assessment dated two nuary 26, 2005) was conducted by athologist at the client's day professional identified that client #2 ng strengths: "following situational of used social commands, making nown through the production of a sign language signs, and labelling a few pictures." The ons included: increase skills in sign language signs, and labelling a few pictures." The ons included: increase skills in sign ling items, and following directions. Ormmended that speech services in setting be similar to the services of day program. Tyram, clients participated in a daily class and instructors were good instructors wer	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G145 PLIER RY STATEMENT OF DEFICIENCIES CICIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) DIPER RY STATEMENT OF DEFICIENCIES CICIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) TAG TO January 6, 2007, March 31, otember 30, 2006. There was no June, and July 2007. For May a reflected that client #1 had a objective once for the month. failed to provide consistent to use recommended methods of ins. Tas observed not using verbal ins, signs, or any communicative in the survey on July 12, 13, and 16 (2's speech assessment dated two mustry 26, 2005) was conducted by athologist at the client's day professional identified that client #2 ing strengths: "following situational was oscial commands, making mown through the production of a sign language signs, and labelling a few pictures." 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The ons included: Increase skills in sign ling items, and following directions. The ons included: Increase skills in sign ling items, and following directions.	CARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIERCILA IDENTIFICATION NUMBER: 09G145 PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012 RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY PULL YOR LISC IDENTIFYING INFORMATION) OF page 17 on January 6, 2007, March 31, otember 30, 2006. There was no June, and July 2007. For May 12 reflected that client #1 had a objective once for the month. failed to provide consistent to use recommended methods of ns. as observed not using verbal ns, signs, or any communicative 1 the survey on July 12, 13, and 16 (2's speech assessment dated two july 26, 2005) was conducted by thologist at the client's day professional identified that client #2 ng strengths: "following situational rused social commands, making nown through the production of a sign language signs, and labelling a few pictures." The ons included: increase skills in sign ling items, and following directions, ommended that speech services in setting be similar to the services day program. Jeram, clients participated in a daily class and instructors were 1, "simple" signs (eat, drink, toilet, communicate. According to the structor and the provided 1, client #2 achieved signing wash/dry hands at the criterion of prompting. No signing was 1, the facility, Staff interviewed on 1.	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had a book of signs and that client #1 helps the

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(W 196)	Continued From page	ge 18	{W 1	96}	· · · · · · · · · · · · · · · · · · ·			
	staff with signing.		•					
	revealed that client staff can request client staff stated that client items and a communicture book nor the	ally 12, 2007 at 11:40 AM #2 knows some signs and that ent #1 to assist them. The int #2 had a picture book of inication device. Neither the communication device were d by the client during the						
one:	6:15 PM, indicated the unresponsive to the Coordinator interview PM stated that a vision program because the with the device while documentation at the disengagement with did include an object communicative device.	interview on July 13, 2007 at hat client #2 "was totally communicative device. The wed on July 16, 2007 at 5:45 t would be made to the day e client did not participate at the facility. The facility reflected 98% the device. Client #2's IPP tive for the client to use his ce to name two different me with total guidance.			·			
	July 13, 2007 at 10:0 was "doing well with for identifying items." performs at 100% fo beverages. It was ful client stands and the	aff who was interviewed on 20 AM indicated that client #2 his low tech language device I It was stated that the client r locating and identifying ther stated that when the instructor signs bathroom he ient #2 utilized some signs	·					
	and language needs manner that would al	nined that client #2's speech were being addressed in a low him the full benefit of re efforts between the two						

programs.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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(W 196)	Continued From pa	ge 19	{W 19	96}			
{W 209}	There was no evide encouraged to engate device as it was not facility during the state device had been outhe facility until July 2:00 PM. 3. According to Clipplan dated March 2 objective that read pre-vocational site of transportation with The documentation 5:45 PM from March exception of one transportation of one transportation of the client in her travel training 483.440(c)(2) INDIVINGENTAL Participation by the client is a minor), or required unless the or inappropriate. This STANDARD is Based on interview facility's QMRP faile individuals parents/	ence that client #2 was age with the communicative to made available to him at the curvey on three days. The stror repairs and arrive back to 12, 2007 at approximately ent #3's individual program 9, 2007, the client had an 'will travel to and from his each Friday using public verbal prompts. reviewed on July 13, 2007 at the 2007 to July 2007, with the all in May 2007, the staff did not the opportunity to participate a program. /IDUAL PROGRAM PLAN client, his or her parent (if the the client's legal guardian is participation is unobtainable and record review, the ed to ensure that the guardians/advocates were	{W 20	3. The facility has imp a schedule to ensure the individual's travel train completed on a regular See attachment #	at each ing is	9.3607	
	treatments; failed to individual's circle of individuals ISP and psychotropic medic. Director and the QA that these letters ha	ons, consents, injuries, or address letters to each supports to inform them of quarterly meetings, and all ations reviews; the Program Consultant failed to ensure we been sent out according to on (POC) dated 8/20/07 for of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{W 209}	five of five clients in #1, #2, #3, and #4) The finding includes Interview with the Q Professional (QMRI 6:18 PM acknowled contacted Client #1 parents/guardians/a about medications, treatments. Further revealed that the let circle of supports to Individual Support F meetings, and all ps not been written or conducted on 8/28/c revealed no letters I in the corresponder documented eviden and the Quality Ass these letters were w indicated in the POC 483.440(c)(3)(iii) INI The comprehensive identify the client's s behavioral manager This STANDARD is Based on observation medical records, the comprehensive fund	cluded in the sample. (Clients is: Rualified Mental Retardation P) on 8/27/07 at approximately liged that the facility have not individuals and individuals is interview with the QMRP liters to each individuals is inform them of individuals information. There was no incertified that written and sent out as information and information in the sament must information in the sament must information in the sample.	{W 2	The QMRP will en parents/guardians/informed of medic consents, injuries, The QMRP will address each individual's of support to inform individuals ISP and meetings, and all program Director Consultant will on operation to ensural letters have been supported to the consultant will on the consultant will be supported by the consultant wi	advocates as cations, and treatments a letter to circle of them of the ad quarterly psychotropic vs. The and the QA versee this re that these sent. See	re ents.	9,260)	

PRINTED: 09/04/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G145 08/28/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW MARJUL HOMES WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {W 214} Continued From page 21 {W 214} Money management assessments Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately have been completed for all 6:50 PM revealed that she has no knowledge of a individuals. The assessments 9.3607 money management assessment for Client #1 or will be filed in each individuals even know how to complete one. Further ISP book. Also, the forms will interview with the QMRP acknowledged that none be updated on the date of the of the clients have a money management assessment. Record review conducted on persons ISP meeting. 8/28/07 at approximately 12:30 PM revealed that Šœ. Attachment #12 Clients #1, #2, #3, #4, and #5 did not have a money assessment located in the records. {W 249} 483.440(d)(1) PROGRAM IMPLEMENTATION {W 249} As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. 1. The QMRP revised individual #3 objective at the end of July. The purpose of this revision was This STANDARD is not met as evidenced by: 9.26.0) Based on staff interviews and record review, the to increase the level of assistant facility failed to ensure that clients were provided that the individual needed inorder the opportunities for continuous active treatment to be successful at achieving the in accordance with their individual program plans goal. The revised goal read that (IPPs) for two of five clients included in the he will write his home address sample. (Client #2 and #3) with the help of a cue card with The findings include: touch prompts as needed twice a week for three consecutive 1. The facility failed to ensure continuous active

treatment by not revising programs after clients

2. Interview with the Qualified Mental Retardation

failed to progress. [Refer to W257]

months See July and August data

collection sheets

PRINTED: 09/04/2007. DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G145 NAME OF PROVIDER OR SUPPLIER MARJUL HOMES (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [W 249] Continued From page 22 Professional (QMRP) on 8/27/07 at approximately 7:15 PM acknowledged that staff had not been using Client #2's communication device in 10	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER MARJUL HOMES CAD IDEFICIENCY MUST BE PRECEDED BY FULL FORCE (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY MUST BE PRECEDED BY FULL FORCE) (MAD HOPE CIENCY) W 249] Continued From page 22 Professional (QMRP) on 8/27/07 at approximately 7.15 PM acknowledged that staff had not been using Client #2/5 communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7.02 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that all facility staffs including the QMRP had been trained by the speech and language pathologists. There was no documented evidence that the objective was being implemented as recommended. W 257} 253. 434.40f(f)(f)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview of client's individual program plan (IPP), documentation of progress, and review			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.			
MARJUL HOMES SUMMARY STATEMENT OF DEFICIENCIES (ACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (W 249) Continued From page 22 Professional (OMRP) on 8/27/07 at approximately 7:15 PM acknowledged that staff had not been using Client #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The OMRP findicated that she was unaware of how to use the communication device. Plan Communication device, and not received training on the used of the communication device. Plan Communication device in indicated that she and the direct care staffs had not received training on the used of the communication device. Plan Communication device in a polycitive that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that the objective was being implemented as recommended. (W 257) 43. 440(f)(1)(iii) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by; Based on interview with the direct care staff at the facility and review of client's individual program plan (IPP), documentation of progress, and review			09G145			001	
MARJUL HOMES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAGE (EACH CORRECTIVE ACTION BOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAGE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY	NAME OF I	PROVIDER OR SUPPLIER		$\frac{1}{1}$	STREET ADDRESS CITY STATE 7ID C		28/2007
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (W 249) Continued From page 22 Professional (QMRP) on 8/27/07 at approximately 7:15 PM acknowledged that staff had not been using Client #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7:02 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that all facility staffs including the QMRP had been trained by the speech and language pathologists. There was no documented evidence that the objective was being implemented as recommended. (W 257) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview with the direct care staff at the facility and review of clients individual program plan (IPP), documentation of progress, and review	MARJUL	_ HOMES			4910 ARKANSAS AVENUE, NW	QDE	
Professional (QMRP) on 8/27/07 at approximately 7:15 PM acknowledged that staff had not been using Client #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7:02 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that the objective was being implemented as recommended. (W 257) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on interview with the direct care staff at the facility and review of client's individual program plan (IPP), documentation of progress, and review	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
(QMRP) notes, the facility failed to ensure that objective criterions that had not been attained by	{W 257}	Professional (QMRI 7:15 PM acknowled using Client #2's co accordance with the at the time of the su that she was unawa communication devindicated that she a not received training communication devindicated that she a not received training communication devindicated that she a not received training communication devindicated that she and received training communication devinded to approximate objective that read device to name two time with total guidal staff in service/orient evidence that all fact had been trained by pathologists. There evidence that the objective that the ob	P) on 8/27/07 at approximately led that staff had not been immunication device in a Individual Support Plan (ISP) arvey. The QMRP indicated are of how to use the ice. The QMRP further and the direct care staffs had gon the used of the ice. Record verification on lately 7:02 PM revealed an will use his communications different items at any given ince. Further review of the latetion record revealed no ility staffs including the QMRP the speech and language was no documented elective was being sommended. OGRAM MONITORING & am plan must be reviewed at I mental retardation ised as necessary, including lations in which the client is ward identified objectives orts have been made. Inot met as evidenced by: with the direct care staff at the client's individual program lation of progress, and review tal Retardation Professional accility failed to ensure that		2. The Staff have been how to correctly operate communication device. QMRP will ensure the is being implemented as	e the And objective	9.2607

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
1			B. WII			1	R
J"		09G145	B. WII	NG		08/2	8/2007
MARJUL	ROVIDER OR SUPPLIER HOMES			49	EET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW /ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND	ULD BE	(X5) COMPLETION DATE
{W 257}	Continued From pa increase the succes The finding includes	ss for the clients.	{W 2	257}			
{W 264}	Professional (QMR 7:07 PM, it was ack objective to "write h of a cue card with c week for 3 consecurevised.	Qualified Mental Retardation P) on 8/27/07 at approximately cnowledged that Client #3's is home address with the help one verbal prompts twice a tive months" had not been	{W 2	:64}	See W 249 #1		
	suggestions to the to programs as they re- restraints, time-out or noxious stimuli, of behavior, protection	uld review, monitor and make facility about its practices and elate to drug usage, physical rooms, application of painful control of inappropriate of client rights and funds, and the committee believes need					
	Based on interview Rights Committee (person signing the aware of the individ side effects, and rig	s not met as evidenced by: and record review, the Human HRC) failed to ensure that the medication/BSP consent was ual's condition, medication, this for four of five clients ple. (Clients #1, #2, #3, and					
		ualified Mental Retardation					
		P) on 8/27/07 at approximately nowledged that the facility's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	G	F	۱ ۲
_/		09G145	B. WING		08/28	3/2007
NAME OF F	ROVIDER OR SUPPLIER		49	EET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW /ASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 264}	HRC had not review signing the medica #1, #2, #3 and #4 vondition, medicating Review of the clien 8/28/07 revealed not the facility's HRC haware of the individual of the indi	wed/discussed the person tion/BSP consents for Clients was aware of the individual's on, side effects and rights. Its records on 8/27/07 and o documented evidenced that ad reviewed and discussed the medication/BSP consents was dual's condition, medication, hts as indicated in the Plan of /20/07. MT OF INAPPROPRIATE R	{W 264}	The human rights committee review and approve the conforms to ensure that the persigning the medication of the individual's condition, medication, side effects and rights.	nsent erson P	9-2607
	Based on interview psychologist failed Plans (BSP) to incomedications accord Correction (POC) of clients included in the 4, and #5). The finding included Interview with the Corressional (QMR 7:18 PM, it was accepsychologist had no Support Plan to income	is not met as evidenced by: and record review, the to revise the Behavior Support orporate all psychotropic ding to the facility's Plan of dated 8/20/07 for five of five the sample. (Clients #1, #2, #3, es: Qualified Mental Retardation (P) on 8/27/07 at approximately knowledged that the ot revised the Behavior clude all psychotropic ents #1, #2, #3, #4, and #5.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
4 •			A. BUII		G		R	
		09G145	B. WIN	 1G		L	28/2007	
	PROVIDER OR SUPPLIER HOMES			49	EEET ADDRESS, CITY, STATE, ZIP CODE 910 ARKANSAS AVENUE, NW VASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
{W 289}	Review of the BSPs at approximately 12 medications were in There was no docu psychologist revised psychotropic medic 483.450(e)(4)(ii) DF Drugs used for continuous processing the process of the BSPs at approximately 12 medical process of the BSPs at approximately 12 med	s for these Clients on 8/28/07 2:45 PM revealed that their no included as part the plans. umented evidence that the ed the BSPs to incorporate all cation. RUG USAGE	{W 28		2. The psychologist will revelete BSP to incorporate the use psychotropic medications. The BSP will be reviewed and approved by the HRC and incorporated into the ISP which is approved by the individual IDT. Attachment # 12.	se of The ich Is	9.2607	
	This STANDARD is Based on interview facility's Qualified M Professional (QMRI topic of an attempt medications was disand the psychiatrist	P) failed to ensure that the at decreasing the psychotropic iscussed with the psychologists traccording to the POC dated live clients included in the						
	Interview with the Q Professional (QMRI 7:25 PM acknowled the psychologist and decreasing Client #2 did not occur on 8/2 dated 8/20/07. The psychotropic medica by the psychiatrist a	Qualified Mental Retardation P) on 8/27/07 at approximately diged that the meeting between digest psychiatrist to discuss 23/07 as indicated in the POC e QMRP indicated that the sation meeting was cancelled and rescheduled for 8/30/07.						
į		psychotropic medication and physician orders, and staff				•		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED R		
'		09G145	B. WIN	IG			28/2007
NAME OF P	ROVIDER OR SUPPLIER			49	EET ADDRESS, CITY, STATE, ZIP COE 10 ARKANSAS AVENUE, NW ASHINGTON, DC 20012	ΣE	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ACTION DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{W 316}	interviews the facility the psychotropic modients (#2) in the second of the finding included. The finding included observed on July 1 was administered (Risperdal 2 mg. To 12, 2007 at 11:40 and presented any could not recall the interviewed on July indicated that client episodes, very infrestaff, interviewed on July indicated the she could his targeted behaved ocumentation from the facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior. The facility's policy was reviewed on July 1 that client #2 had extrageted behavior.	ty failed to attempt to decrease edications for one of three ample. s: ion administration that was 2, 2007 at 7:10 PM, client #2 Clonazepam 0.5 mg and he LPN, interviewed on July AM, indicated that client #2 had behavioral episodes and she last episode. Another staff, 713, 2007 at 6:15 PM, the 2 "has not had too many equent". The day program in July 13, 2007 at 10:00 AM, do not recall the client displaying ior. The behavioral manual August 2006 to June 2007, 3, 2007 at 6:20 PM, reflected exhibited four incidents of his of physical aggression. Ton psychotropic medications uly 13, 2007 at 3:35 PM. The at "for individuals receiving prolonged period of time, it is make a systematic and diattempt to reduce and/or ations in order to know if they appropriate."		322}	At the last psychotropic medication review of Au the psychiatrist was info the need to make an atte deceasing individual #4 psychotropic medication psychiatrist explained the policy is only to make a reduction in a persons psychotropic medication zero targeted behavior hexhibited for eight consemonths.	ngust 23 primed of empt at n. The nat his n after nave been ecutive	9.2607

CENTE		& MEDICAID SERVICES					M APPROVE D. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE		<u> </u>
<u>.</u>		09G145	B. Wi	NG,		08/	R 28/2007	
	PROVIDER OR SUPPLIER L HOMES			ĺ	TREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW WASHINGTON, DC 20012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	_
{W 322}	Continued From pageneral medical car		€ W 3	22]	}			
	Based on medical re to ensure medical pi care through timely	s not met as evidenced by: ecord review, the facility failed reventive and general medical appointments and follow up s included in the sample.						
	The findings include	:						
_	Professional (QMRP 8/27/07 at approximation documented evidence evidence)	Qualified Mental Retardation) and record verification on ately 7:28 PM revealed no be that Client #2's prolactin pleted since July 2007.						
	Professional (QMRP approximately 7:33 F Client #3 had not reticolonoscopy follow u recommended. The	Qualified Mental Retardation) on the same day at at PM, it was acknowledged that urned to back for his p visit in one year as QMRP indicated that Client appointment was back in						
	************	*******	<i>^</i>					
	to ensure medical pre care through timely a	cord review, the facility failed eventive and general medical ppointments and follow up s in the primary sample.		`				
	The finding includes:		•					
	During the medica	tion administration that was						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/04/2007

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL			
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		09G145	D. VIIIO _		:	08/2	28/2007	
MARJUL	PROVIDER OR SUPPLIER - HOMES		4	REET ADDRESS, CITY, STATE, Z 1910 ARKANSAS AVENUE, NV NASHINGTON, DC 20012				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOU THE APPR	JLD BE	(X5) COMPLETION DATE	
{W 322}	administered Clona 2 mg. The physicia reviewed on July 12 PM. The POS identification blood sugar levels, (CMP), profactin levery three in survey, there was not these studies had be 2006. 2. According to the April 28, 2007, clien	2, 2007 at 7:10 PM, client #2 zepam 0.5 mg and Risperdal an's orders (POS) were, 2007 at approximately 2:00 tified the need for fasting complete metabolic profile els every six months, and lipid nonths. At the time of the o documented evidence that een conducted since July	{W 322}	a. Individual #2's prinave been tested. So #15	ee attach	ment	9.26.07	
{W 331}	client #3 had not ret conducted. 483.460(c) NURSIN The facility must pro	At the time of the survey, urned to have the testing G SERVICES vide clients with nursing nee with their needs.	{W 331}			·		
	Based on observation review, the facility fa services were provided to the services were provide	not met as evidenced by: on, interviews, and record iled to ensure that nursing led in accordance with clients clients in the sample (Clients	·					
	Professional (QMRF 8/27/07 at approxim documented evidence	: Qualified Mental Retardation and record verification on ately 7:28 PM revealed no the that Client #2's prolactin apleted since July 2006.						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE	SURVEY LETED	
· '		09G145	B. WIN			00	R	
	PROVIDER OR SUPPLIER HOMES			49	EET ADDRESS, CITY, STATE, ZIP CODE 210 ARKANSAS AVENUE, NW (ASHINGTON, DC 20012		<u> 28/2007 </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{W 331}	b. Interview with the Professional (QMRI approximately 7:33 Client #3 had not recolonoscopy follow recommended. The #2 last colonoscopy June 2006. Based on observation review, the facility faservices were provided.	e Qualified Mental Retardation P) on the same day at at PM, it was acknowledged that turned to back for his up visit in one year as e QMRP indicated that Client appointment was back in on, interviews, and record illed to ensure that nursing ded in accordance with clients ee clients in the sample (#2,	{W 3:	31}				
	observed on July 12 administered Clonaz 2 mg. The physicia reviewed on July 12, PM. The POS identification blood sugar levels, c (CMP), prolactin levels profile every three m survey, there was not these studies had be 2006. 2. According to the records, conducted of the client had a biops the record revealed.	ation administration that was 2007 at 7:10 PM, client #2 epam 0.5 mg and Risperdal n's orders (POS) were 2007 at approximately 2:00 fied the need for fasting omplete metabolic profile els every six months, and lipid onths. At the time of the documented evidence that en conducted since July eview of Client 3's medical on July 12, 2007 at 2:26 PM, sy performed in May 2006. that the client had polyps, of the biopsy was not apart of		a	1. a. Individual #2's prolaction levels have been tested. Se attachment # 15 2. The result of the colonscore in the individuals chart. Se attachment # 10	e —	9,2607	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
i		09G145	B. WIN	IG			R 8/2007
NAME OF P	ROVIDER OR SUPPLIER		·- 	49	EET ADDRESS, CITY, STATE, ZIP CODE 10 ARKANSAS AVENUE, NW IASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{W 331}	Continued From pa	age 30	{W 3	31}			
	April 28, 2007, clier colonoscopy in Jun return in one year. client #3 had not re	e nursing assessment dated int #3 was seen for a see 2006 and was required to At the time of the survey, eturned to have the testing			3. See W 331 #2		
{W 441}	conducted. 483.470(i)(1) EVAC	CUATION DRILLS	{W 4	41}			
	varied conditions. This STANDARD is Based on the revier failed to ensure that	is not met as evidenced by: w of fire drill records the facility at clients in the facility had been ted to evacuate the facility p hours.		-	The fire drill schedule has be revised and will be implement by the Home Supervisor and be checked regularly by the Consultant. See Attachment	nted will QA	9.2607
	The finding include	s:			· ·		
	Professional (QMR approximately 7:33 fire drill scheduled implemented by the checked regularly be	Qualified Mental Retardation P) on the same day at at PM, it was acknowledged the has not been revised and home supervisor and by the QA consultant as an of Correction dated 8/20/07.					
				•			

PRINTED: 09/04/2007 FORM APPROVED

If continuation sheet 1 of 11

09G145			DENTIFICATION NUMBER:		PLE CONSTRUCTION G	COMPLETED R 08/28/2007	
		,					
NAME OF F	PROVIDER OR SUPPLIER		l		STATE, ZIP CODE		
MARJUL	HOMES			KANSAS AVE GTON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE YMUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE	
{1 000}	INITIAL COMMENT	гѕ		{1 000}			
	August 27 and 28, 2 included three resid survey conducted o	sure survey was con 2007. The resident s lents selected from t in July 13, 2007 and not in the previous s	ampling he initial two other				
{I 056}	preparation and ser care of equipment,	train staff in the stor ving of food, the clean and food preparation conditions at all time	rage, aning and n in order	{1 056}			
	Based on interview	met as evidenced by and record review, t illed to have a facility ndlers certification.	he				
	The finding includes	5 :					
leaith Regula	Professional (QMRF approximately 7:43 no facility working the 12:00 AM) had food Further interview with food handlers training for 9/5/07. Review of service/orientation mapproximately 11:15 schedule working the certification. There that staff had receive the time of the surve	PM, it was acknowled be second shift (4:00) handlers certification that the QMRP revealed by class has been so of the staff in ecords on 8/28/07 at a second had food has no documented bed food handlers trained second shandlers trained second sec	edged that PM to n. ed that a cheduled t aff on nandlers evidence		A Food Handlers Train Team leaders was September 12 th , 2007. facility's Office Mana ensure that all staff ke Food Handlers Trainin current. See Attachm	ning for all s held on The ger will ep their ng license	9.260)
lealth Regula	ation Administration	11/1			THILE	1	(X6) DATE
.BORATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENT	TATIVE'S SIG	NATURE	MIMMUNA	h/ .	9.11.0

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	ROVIDER OR SUPPLIER	09G145	4910 ARK	DRESS, CITY, S (ANSAS AVE STON, DC 20		08/28/2007
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{I 056} Continued From page 1 The finding includes: Staff files and trainings were reviewed on Ju 2007 at 5:15 PM. The "Acting Qualified Me Retardation Professional" stated that the fa was working on getting food service training		Mental ne facility ining for	{ 056}			
{I 160}	were no certified for 3507.1 POLICIES A Each GHMRP shall describing the polici follow which shall be		en manual it will ecessary	{I 160}	. •	
	This Statute is not a The findings included. 1. Interview with the Professional (QMRI approximately 5:58 the facility have not and #4's advocate, members to obtain them about the use	e each staff member met as evidenced by e: e Qualified Mental R P) on 8/27/07 at PM, it was acknowle contacted Clients # legal guardian, and/ consents forms or in and side effects of	etardation edged that 1, #2, #3, or family form		1. See W104	
	currently prescribed Support Plan (ISP) approximately 5:50 forms had been obt There was no docur parents/guardians/a all medications and have given consent	ations in which they I. Review of the Indi records on 8/27/07 a PM revealed no con ained for Clients 1 the mented evidence the advocates had been their side effects, ar for all treatments as ction dated 8/20/07.	vidual at sents nrough 4. at the informed and they		5. See W 196 & <u>W 246</u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		09G145		B. WING_		· ·	R 28/2007	
NAME OF F	PROVIDER OR SUPPLIER	-	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
MARJUL	HOMES			KANSAS AVENUE, NW GTON, DC 20012				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
{ 160}	Continued From pa	ge 2		{I 160}				
	a consistent and pe in W249 and W196	ersistent manner as c	lescribed					
	policies were implei	ody failed to ensure mented to ensure the rights. [See W264]				•		
{ 206}	3509.6 PERSONNE	EL POLICIES		{1 206}				
	annually thereafter, certification that a h performed and that	or to employment an shall provide a phys ealth inventory has t the employee 's hea her to perform the re	ician 's een alth status		2. The home supervisor will inform all staff that they are required to have an annual physical in order to work in facility. All staff will have a current physical examination	the a n on	9.26.07	
	Based on interview	met as evidenced by and record review, th sure that all staff ha n file.	ne .		file and any staff that are unto produce one will be suspet without pay until they are at _produce one	nded	£	
	The findings include	es;						
	8/28/07 at approximathe following staffs a	nnel records conduct ately 11:15 AM reve are without current he 5, S9, S10, and S11]	aled that	٠	·			
{ 209}	3509.9(a) PERSON	NEL POLICIES		{ 209}				
	references on each	obtain employment employee and no Gl vidual who has a his			·			
	(a) Child or resident	abuse or abuse of s	omeone					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		09G145		A. BUILDIN B. WING	· · · · · · · · · · · · · · · · · · ·	08/2			
NAME OF P	ROVIDER OR SUPPLIER	1 000140	STREET AD	ADDRESS, CITY, STATE, ZIP CODE					
MARJUL	HOMES			KANSAS AVENUE, NW GTON, DC 20012					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE			
{I 209}	Review of the person 8/28/07 at approximation the following staffs clearances for the sign of the sign	re and supervision; met as evidenced by s: connel records conducted to the services of Maryland: [State of	cted on saled that olice 7-MD, ENERAL fied or sof every d to be The sot be dividuals sed by	{I 395}	The home supervisor will is all staff that they are require obtain police clearance from jurisdiction in which they have worked or resided in within years of their employment of the facility. All staff will have police clearance on file and staff that are unable to produce will be suspended with pay until they are able to produce.	ed to a n the ave seven with ave a any uce out	9.24.07		
	Retardation Professiverification on 8/27/	he Qualified Mental sional (QMRP) and re 07 at approximately ented evidence that	7:28 PM		1. See W 331a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE		1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BUILDIN B. WING		F			
*		09G145				08/2	8/2007		
NAME OF P	ROVIDER OR SUPPLIER	•			STATE, ZIP CODE		·		
MARJUL	. HOMES			KANSAS AVENUE, NW GTON, DC 20012					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE		
{ 395}	' "			{ 395}					
,	#2's prolactin levels had been completed since July 2007.b. Interview with the Qualified Mental Retardation Professional (QMRP) on the same day at at				1b. See W 331b				
Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged that Client #3 had not returned to back for his colonoscopy follow up visit in one year as recommended. The QMRP indicated that Client #2 last colonoscopy appointment was back in									
	June 2006. 2. See Federal Deficiency Report Citations W331		ons		2. See W 331		·		
{ 401}	3520.3 PROFESSIO PROVISIONS	ON SERVICES: GEN	IERAL	{I 401}					
	Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on interview and record verification, the GHMRP failed to ensure professional services were provided timely for two of three residents in the survey. (Residents #2 and #3)		f ent ent		·	·			
			on, the ervices						
	The findings include	:							
	1a. Interview with the Qualified Mental Retardation Professional (QMRP) and record verification on 8/27/07 at approximately 7:28 PM revealed no documented evidence that Resident #2's prolactin levels had been completed since July 2006.			a. See W 331a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ 09G145 08/28/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4910 ARKANSAS AVENUE, NW **MARJUL HOMES** WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) {| 401} Continued From page 5 {| 401} b. Interview with the Qualified Mental Retardation b. See W 331b Professional (QMRP) on the same day at at approximately 7:33 PM, it was acknowledged that Resident #3 had not returned to back for his colonoscopy follow up visit in one year as recommended. The QMRP indicated that Resident #2 last colonoscopy appointment was back in June 2006. (1408) 3520.10(a) PROFESSION SERVICES: {1 408} GENERAL PROVISIONS Professional services personnel shall offer consultation and instruction as appropriate to the following: (a) The resident 's family; and... This Statute is not met as evidenced by: The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 6:18 PM acknowledged that the 1. See W 148 & W 209 facility have not contacted Client #1, #2, #3, #4, and #5's parents/guardians/advocates to inform them about medications, consents, injuries or treatments. Further interview with the QMRP revealed that the letters to each individuals's circle of supports to inform them of individuals Individual Support Plans (ISP), quarterly meetings, and all psychotropic medications had not been written or mailed out. Record reviews conducted on 8/28/07 at approximately 12:23 PM revealed no letters had been written or mailed out in the correspondence section. There was no documented evidence that the Program Director and the Quality Assurance Consult ensured that these letters were written and sent out as

indicated in the POC dated 8/20/07.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
<u>~</u>		09G145				08/28	/2007
,,,,,,,,,	4910 AR			ANSAS AVI TON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{1 408}	Continued From pa	ge 6		{I 408}			
	Professional (QMR approximately 7:15 the facility's HRC has person signing the aware of the individual side effects and right records on 8/27/07 documented evider had reviewed and of the medication/BSF individual's conditionand rights as indicational.	e Qualified Mental R P) on 8/27/07 at PM, it was acknowle ad not reviewed/disc medication/BSP consitual's condition, medi hts. Review of the cl and 8/28/07 revealed need that the facility's discussed the person P consents is aware of on, medication, side ented in the POC dated deficiency report date	edged that ussed the sents is cation, ients d no HRC signing of the effects d 8/20/07.		2. See W 264 3. See W 124		
{1 422}	Each GHMRP shall and assistance to re the resident 's India This Statute is not Based on observati review, the GHMRP #2, and #3 were pro	ION AND TRAINING provide habilitation, esidents in accordan vidual Habilitation Plamet as evidenced by ion, interview and recorded to ensure Repovided habilitation, train Individual Habilitati	training ce with an. cord sidents aining and	{I 422}			
	treatment by not refailed to progress. 2. Interview with the Professional (QMR)	d to ensure continuou vising programs after [Refer to W257] e Qualified Mental R	clients etardation		1. W249 2. 196, & 189 #3		
Health Regul	lation Administration	· ··· acimomoagea ti	0,0,1			<u> </u>	

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	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
·		09G145		B. WING		08/28/2007				
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	ADDRESS, CITY, STATE, ZIP CODE						
MARJUL	HOMES			KKANSAS AVENUE, NW IGTON, DC 20012						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE			
{ 422}	had not been using Resident #2's communication device in accordance with the Individual Support Plan (ISP) at the time of the survey. The QMRP indicated that she was unaware of how to use the communication device. The QMRP further indicated that she and the direct care staffs had not received training on the used of the communication device. Record verification on 8/27/07 at approximately 7:02 PM revealed an objective that read "will use his communications device to name two different items at any given time with total guidance. Further review of the staff in service/orientation record revealed no evidence that all facility staffs including the QMRP had been trained by the speech and language pathologists. There was no documented evidence that the objective was being implemented as recommended.			{1 422}						
{I 423}	resident's Individual ongoing basis to entresident and appropriate of such Plans when for the reviews shall IHP. This Statute is not represent the Based on interview, Qualified Mental Re (QMRP) failed to entresident of the state of the st	monitor and review all Habilitation Plan of sure participation of oriate GHMRP staff in ever necessary. The libe documented with met as evidenced by and record review, that tardation Profession sure the coordination to clients included in #2, #3,#4, and #5)	each n an the n revision schedule nin each he al	{ 423}						

			ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R		
		09G145		B. WING		08/28	3/2007	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
MARJUL	HOMES			ANSAS AVE				
(X4) ID. PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
{ 423}	Continued From pa	age 8		{I 423}				
	The QMRP failed to ensure that clients received continuous active treatment services. [Refer to W196, W249]			1. W 196 & W 249				
	2. The QMRP failed to ensure that clients' objective criterions, that had not been attained, had been considered for revision to increase the success for the clients.[Refer to W257]			2. W 257				
{1 426}	3521.5(c) HABILITATION AND TRAINING		NG	{I 426}				
	Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client:							
	(c) Is failing to prog objectives after rea made;	gress toward identifie asonable efforts have	ed e been					
	Based on interview Qualified Mental R (QMRP) failed to e considered when o achievement in att	t met as evidenced by and record review, etardation Profession ensure that revisions elients' demonstrated aining the establishe of five residents in the	the nal were a lack of d criterion					
ll	The findings include	de:						
	2. Interview with the Qualified Mental Retardation Professional (QMRP) on 8/27/07 at approximately 7:07 PM, it was acknowledged that Resident #3's objective to "write his home address with the help of a cue card with one verbal prompts twice a week for 3 consecutive months" had not been revised.			1. W246#1				
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 08/28/2007		
		09G145	STREET AN	DRESS, CITY, STATE, ZIP CODE				
MARJUL	ROVIDER OR SUPPLIER . HOMES		4910 ARK	CANSAS AVENUE, NW STON, DC 20012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	THE APPROPRIATE DA		
{1 500}	Continued From page 9			{1 500}				
{I 500}	3523.1 RESIDENT'S RIGHTS			{ 500}				
	that the rights of re	dence director shall esidents are observed dance with D.C. Law applicable District ar	d and 2-137, this					
	Based on observativerification, the fact each client or their of the client's mediand behavioral state treatment, and the	t met as evidenced be tion, interview and re cility failed to ensure of legal guardian to be ical condition, develoc tus, attendant risks of right to refuse treatment included in the samp	cord the right of informed opmental of nent for					
	The findings include:							
	Retardation Profest approximately 5:56 the facility have not and #4's advocate members to obtain them about the us psychotropic medicurrently prescribed Support Plan (ISP approximately 5:56 forms had been of There was no docuparents/guardians all medications and	the Qualified Mental ssional (QMRP) on 8 8 PM, it was acknowled to contacted Clients for an acceptance of the local state of th	ledged that \$1, #2, #3, /or family inform / were dividual at nsents through 4. nat the n informed and they		1. W249 & W 14 2. W249 & W 148	8_		
	2. Interview with the Qualified Mental Retardation							

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AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPLE F	(X3) DATE SURVEY COMPLETED R 08/28/2007	
NAME OF F	PROVIDER OR SUPPLIER	030143	STREET AD	ADDRESS, CITY, STATE, ZIP CODE		1 00/2	00/20/2001	
	- HOMES		4910 ARI	(ANSAS AVI STON, DC 2	ENUE, NW		·	
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